Incident Report

Updated April 2017

IMMEDIATE ACTION: SEEK MEDICAL ADVISE AND REPORT TO YOUR MANAGER/SUPERVISOR. FOR ALL OTHER INCIDENTS, INJURIES OR NEAR MISSES PLEASE FILL OUT THIS FORM.

Injured Persons details

Name: _____ Address:_____

Phone:_____ Email:_____

Occupation/Location of employment:_____

Date of report: / /

Accident/incident details

Date:_____ Time:_____AM/PM Date reported: / /

Location:_____

Witness details: _____

Reported to whom: _____

Full accident/incident details – what happened, or in the case of a near miss, what could have happened -

_____

_____

_____

_____

_____

Injury – Nature of Injury

☐ Contusion/crush ☐ Burn ☐ Dislocation ☐ Amputation

☐ Laceration/open wound ☐ Superficial injury ☐ Foreign body ☐ Needle Stick

☐ Concussion ☐ Sprain/strain ☐ Fracture ☐ Dermatitis

Location of Injury (please also state which side of body):

☐ Head/face ☐ Eye ☐ Hand/fingers ☐ Shoulder/arms

☐ Trunk (other than back) ☐ Hip/leg ☐ Foot/toes ☐ Back

☐ Other (state)

Results of accident

Lost time due to injury Y / N No. of days: _____ days

Workers' compensation Y / N

Treatment received

☐ First aid ☐ Doctor ☐ Hospital

If doctor or hospital please state practice name, address and contact number:

_____

_____

Damage to equipment/buildings/vehicles etc

What was damaged?

_____

_____

Extent of damage:

_____

_____

Contributing factors

What were the contributing factors (if any)?

_____

_____

Corrective actions

Immediate actions

_____

_____

What controls can be put in place to prevent this from happening again?

_____

_____

Recommendations for action

_____

_____

Who is to implement these controls/corrective actions?_____

_____ Date by which action is to be taken / /

Signatures

Manager: Director:

Person who received injuries:

Actions completed:

Date: / / Manager :